Medical Documentation and Coding 1997 Guidelines

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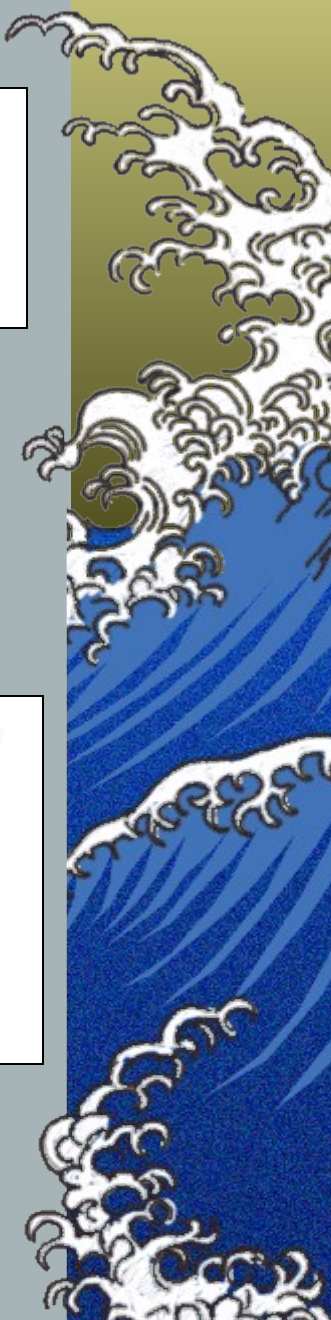
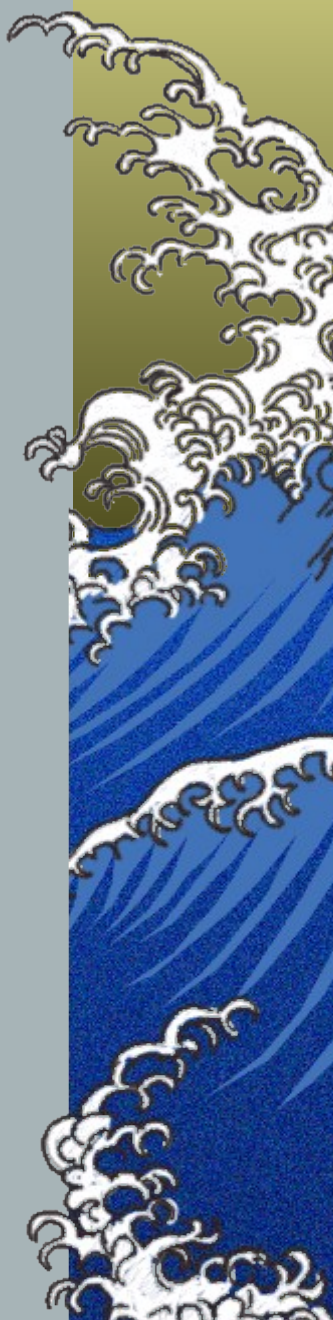


Outline

- *The Importance of Documentation*
- *What Payer's Want*
- *Principles of Medical Record Documentation*
- *Documentation of E/M Services*
- *Documentation of History*
- *Chief Complaint(CC)*

Outline cont'd

- *History of Present Illness (HPI)*
- *Review of Systems (ROS)*
- *Past, Family and/or Social History (PFSH)*
- *Documentation of Examination*
- *General Multi-System Examinations*
- *Single Organ System Examinations*



The Importance of Documentation

- *Medical record documentation is required to:*
  - *Record pertinent facts, findings, and observations about an individuals health history*
- *An individual's health history may consists of:*
  - *Past and present illnesses, examinations, tests, treatments, and outcomes*

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The Importance of Documentation cont'd

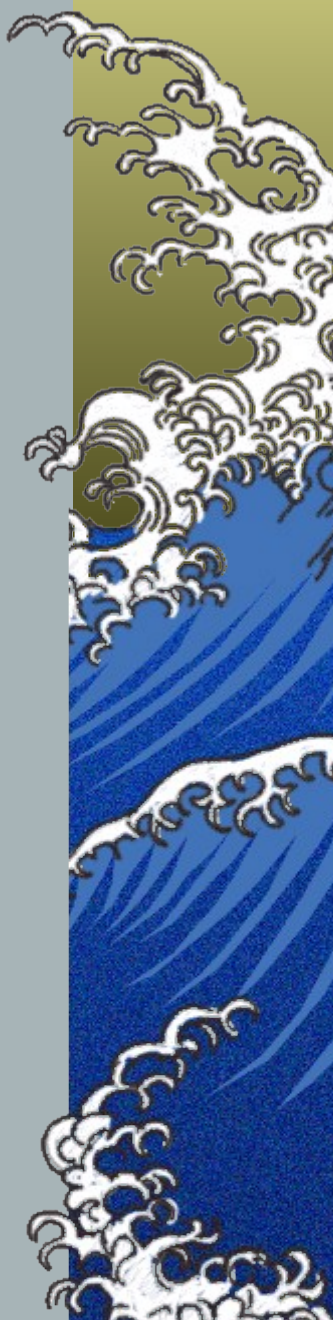
- *The medical record chronologically documents the care of the patient and is an important element which contributes to high quality care.*

- *The medical record facilitates:*

  - *Ability to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time*

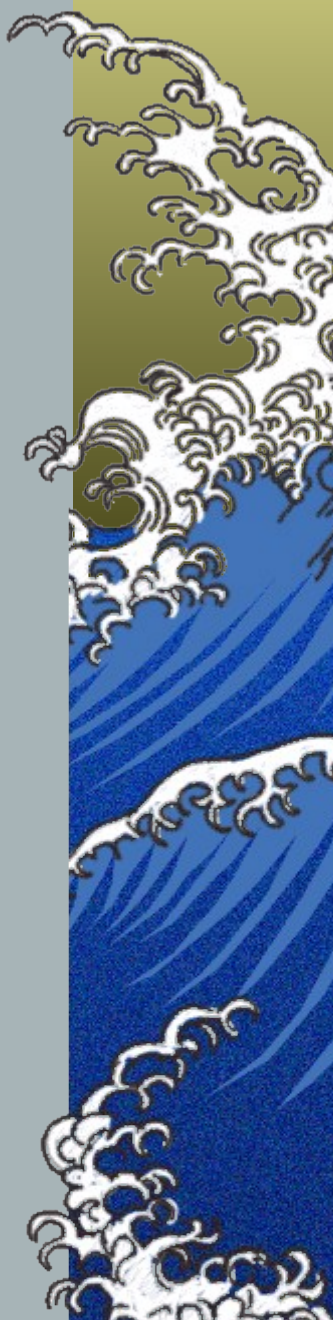
The Importance of Documentation cont'd

- *Communication and continuity of care*
- *Accurate and timely claims review and payment*
- *Appropriate utilization review and quality of care evaluations*
- *Collection of data useful for research and education*



The Importance Documentation cont'd

- *An appropriately documented medical record can:*
- *Reduce the hassle associated with claims processing*
- *Serve as a legal document to verify care provided*



What Payers Want

- *Payers have a contractual obligation to enrollees thus they require reasonable documentation to show that the services rendered are consistent with the insurance coverage provided.*
- ***Valid information of services rendered:***
  - *Site of service*
  - *Medical necessity and appropriateness of the diagnostic and/or therapeutic services provided*
  - *Services provided accurately reported*

Principals of Medical Record Documentation

- *Principles applicable to all types of medical and surgical services in all settings.*

- ***For Evaluation and Management (E&M) services the nature and amount of physician work and documentation varies by:***

  - *Type of service*
  - *Place of service*
  - *Patient's status*

Principals of Medical Record Documentation cont'd

- *The medical record should be complete and legible.*
- ***Documentation of each patient encounter should include:***
  - *Reason for encounter*
  - *Relevant history*
  - *Physical examination findings and prior diagnostic tests results*

Principals of Medical Record Documentation cont'd

- *Assessment, clinical impression or diagnosis*
- *Plan of care*
- *Date and legible identity of the observer*

- *In the absence of documentation, the rationale for ordering diagnostic and other ancillary services should easily inferred*

- *Past and present diagnoses accessible to the treating and/or consulting physician*

Principles cont'd

- *Identification of appropriate health risk factors*
- *Documentation of the patient's progress, response to changes in treatment, and revision of diagnosis*
- *Documentation to support CPT and ICD-9-CM codes should be reported on the health insurance claim form or billing statement*

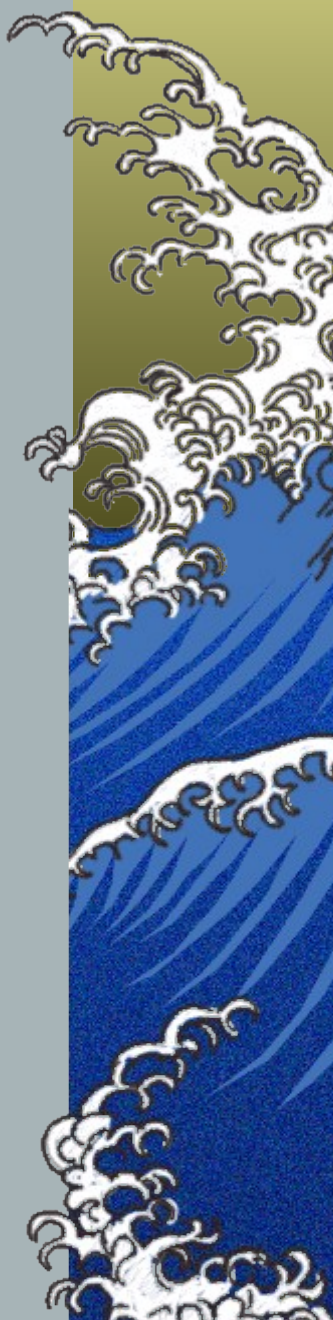
Documentation of E/M Services

- ***E/M services and visits for counseling and coordination of care***

- ***Three key components:***
  - *History*
  - *Examination*
  - *Medical decision-making*

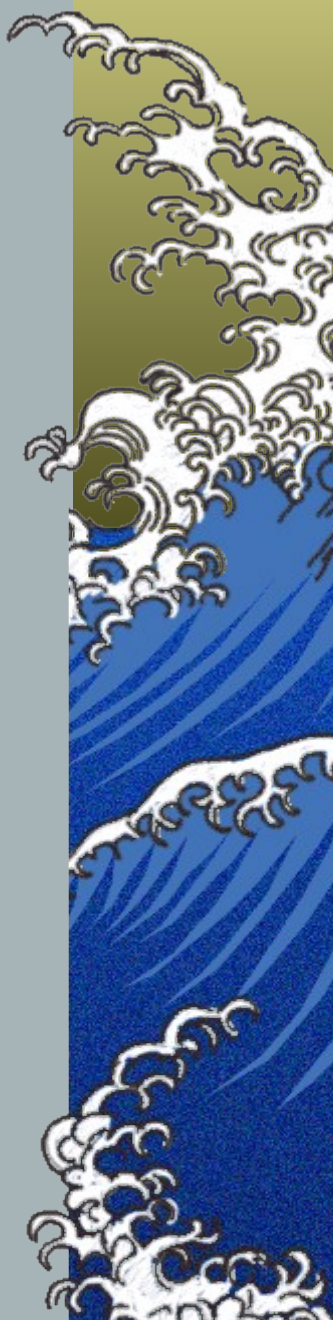
Documentation of E/M Services cont'd

- ***Used for the following services:***
  - *Office and other Outpatient services*
  - *Hospital Observation Services*
  - *Hospital Inpatient Services*
  - *Consultations*



Documentation of E/M Services cont'd

- *Emergency Department Services*
- *Nursing Facility Services*
- *Domiciliary Care Services*
- *Home Services*



Documentation of E/M Services cont'd

- ***Descriptors for the levels of E/M Services:***

- *History*
- *Examination*
- *Medical Decision-Making*
- *Counseling*
- *Coordination of Care*
- *Nature of Presenting Problem*
- *Time*

Documentation of History

- ***Based on four types of history:***
- *Chief Complaint (CC)*
- *History of Present Illness (HPI)*
- *Review of Systems (ROS)*
- *Past, Family and /or Social History (PFSH)*

Documentation of History cont'd

History of Present Illness (HPI)	***Review of Systems (ROS)***	***Past, Family and/or Social History (PFSH)***	***Type of History***
Brief	*N/A*	*N/A*	***Problem Focused***
Brief	*Problem Pertinent*	*N/A*	***Expanded Problem Focused***
Extended	*Extended*	*Pertinent*	***Detailed***
Extended	*Complete*	*Complete*	***Comprehensive***

Chief Complaint (CC)

- **Chief Complaint** *(CC) - concise statement describing the:*
  - *Symptom Problem*
  - *Condition Diagnosis*
  - *Physician recommended other factor that is return the reason for the encounter*
- *Usually stated in the patient's own words.*

History of Present Illness (HPI)

- ***History of the Present Illness (HPI)*** *– chronological description of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present.*

- *Included in the assessment:*
  - *Location* *Quality*
  - *Severity* *Duration*
  - *Timing* *Context*
  - *Modifying factors* *Associated signs and symptoms*

Review of Systems (ROS)

- *Review of Systems (ROS):*

- ***Inventory of body systems obtained through a series of questions seeking to identify:***

  - *signs and/or symptoms the patient may be experiencing or has experienced.*

Review of Systems (ROS) cont'd

- ***For purposes of ROS, the following systems are recognized:***
  - *Constitutional symptoms (e.g., fever, weight loss)*
  - *Eyes Ears, Nose, Mouth, Throat*
  - *Cardiovascular Respiratory*
  - *Gastrointestinal Genitourinary*

Review of Systems (ROS) cont'd

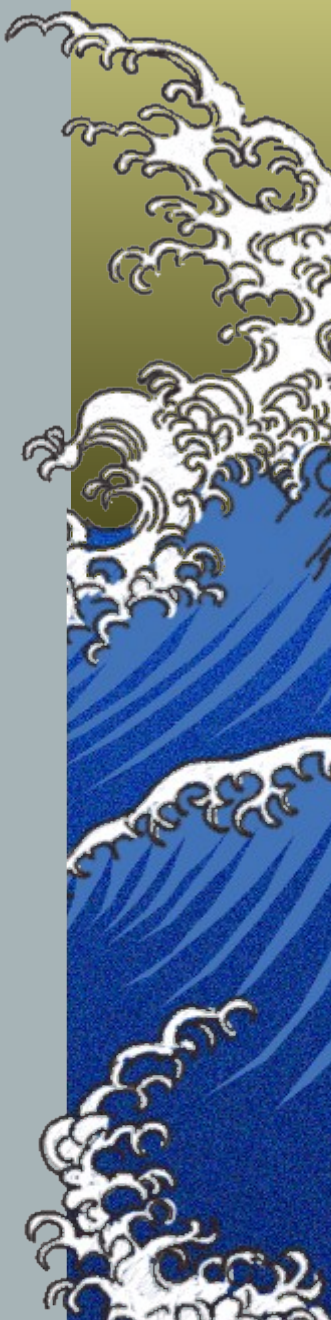
- *Musculoskeletal*
- *Integument (skin and/or breast)*
- *Neurological*
- *Psychiatric*
- *Endocrine*
- *Hematologic/ Lymphatic*
- *Allergic/Immunologic*

Past, Family and/or Social History (PFSH)

- ***Past history -*** *(the patient's past experiences with illnesses, operations, injuries and treatments*

- ***family history -*** *(a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)*

- ***Social history -*** *(an age appropriate review of past and current activities).*



Past, Family and/or Social History (PFSH)

- *CPT requires only an "interval" history for categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care. In these instances it is not necessary to record information about the PFSH.*

Documentation of Examination

- ***E/M levels of service are based on four types of examinations as follows:***
  - **Problem Focused** -- *a limited examination of the affected body area or organ system.*
  - **Expanded Problem Focused** -- *a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).*

Documentation of Examination cont'd

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  - **Problem Focused** -- *a limited examination of the affected body area or organ system.*
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Documentation of Examination cont'd

- **Detailed** -- *an extended examination of the affected body area(s) and other symptomatic or related organ system(s).*

- **Comprehensive** -- *a general multi-system examination or complete examination of a single organ system.*

Documentation of Examination cont'd

- *These types of examinations have been defined for general multi-system and the following single organ system(s).*

- *Cardiovascular*
- *Ears, Nose, Mouth and Throat*
- *Eyes*
- *Genitourinary (Female)*

Documentation of Examination cont'd

- *Genitourinary (Male) Hematologic/Lymphatic/ Immunologic*
- *Musculoskeletal Neurological*
- *Psychiatric Respiratory*
- *Skin*

General Multi-System Examinations

- ***Qualification for a given level of multi-system examination is based on meeting the following content and documentation requirements:***

- ***Problem Focused Examination -*** *should include performance and documentation of one to five elements identified by a bullet (·) in one or more organ system(s) or body area(s).*

- ***Expanded Problem Focused Examination -*** *should include performance and documentation of at least six elements identified by a bullet (·) in one or more organ system(s) or body area(s).*

General Multi-System Examinations cont'd

- ***Detailed Examination:***
- *include at least six organ systems or body areas.*
- *For each system/area selected, performance and documentation of at least two elements identified by a bullet (·) is expected.*
- *Alternatively, a detailed examination may include:*

  performance and documentation of at least twelve elements identified by a bullet (·) in two or more organ systems or body areas.

General Multi-System Examinations cont'd

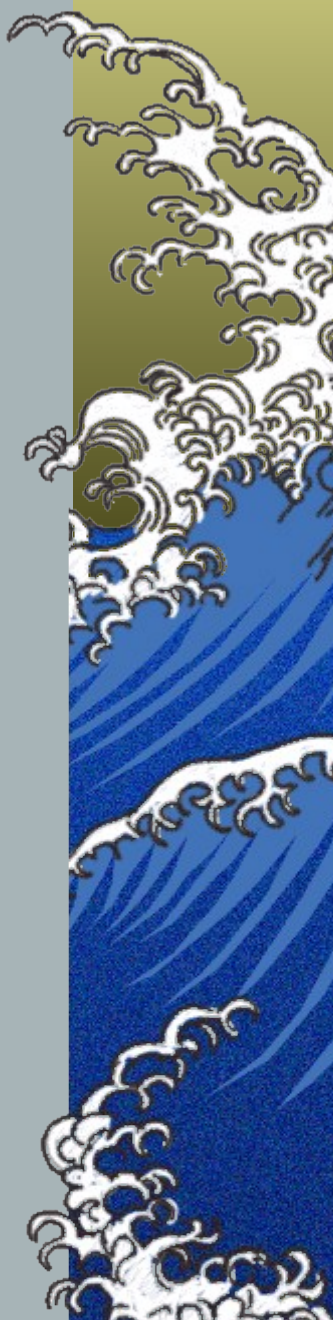
- ***Comprehensive Examination:***
  - *include at least nine organ systems or body areas.*
  - *For each system/area selected, all elements of the examination identified by a bullet (·) should be performed, unless specific directions limit the content of the examination.*
  - *For each area/system, documentation of at least two elements identified by a bullet is expected.*

Single Organ-System Examinations

- ***To qualify for a given level of single organ system examination, the following content and documentation requirements should be met:***

- ***Problem Focused Examination --*** *should include performance and documentation of one to five elements identified by a bullet (·).*

- ***Expanded Problem Focused Examination --*** *should include performance and documentation of at least six elements identified by a bullet (·).*



Single Organ-System Examinations

- ***Detailed Examination****--examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (·).*
- *Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (·).*

- ***Comprehensive Examination****--should include performance of all elements identified by a bullet (·).*